VOLUNTARY BENEFITS ADMINISTRATORS, INC.

PREMIUM REDUCTION OPTION PLUS FSAs

DATA GATHERING FORM

Name of Organization: _____
(Enter name exactly as it appears on tax returns and is to appear in the documents.)

Federal Employer ID No: _____ Date Incorporated/Organized: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Street Address: _____ Zip: _____

Organization Type:

- ☐ Corporation
- ☐ Professional Corporation
- ☐ Partnership
- ☐ Government Agency
- ☐ Other _____
- ☐ Sub-chapter "S" Corporation
- ☐ Professional Association
- ☐ Sole Proprietorship
- ☐ LLC Limited Liability Company

NOTE: Only employees can participate in a cafeteria plan. Thus, while partnerships, sole proprietorships and Sub-chapter "S" corporations may sponsor cafeteria plans, the following cannot participate: sole proprietors, partners, and greater than 2% shareholders in Sub-chapter "S" corporations.

The Employer/Organization entity is operating pursuant to the laws of the State of _____
Principal Business Activity Code: __ __ __ __ __ __

Nature of Business: _____

PLAN ELECTIONS SECTION 125 CAFETERIA PLAN

Current Plan Effective Date: ___/___/___ New or Amended Plan Year Begins: ___/___/___

Current Plan End Date: ___/___/___ New or Amended Plan End Date: ___/___/____

Grace Period 2.5 Months ____ OR Rollover $500 _____

ELIGIBILITY REQUIREMENTS

1. Number of eligible employees: _____
2. The following class of employees is eligible to participate
   ___ All ___ Salaried Employees Only ___ Hourly Employees Only
   ___ Other _____
   Tax penalties may be imposed if the Plan contains eligibility requirements that have the effect of favoring highly compensated employees. Consult your tax advisor before limiting participation in the Plan.
3. The following employees are excluded from participation:

- ☐ No Exclusions.
- ☐ Part-time employees normally expected to work less than _____ hours a week.
- ☐ Employees under the age of _____.
- ☐ Union employees (unless the bargaining agreement provides for coverage).
- ☐ Non-resident aliens.
- ☐ Other:_____

Section 125 does not specifically provide for election exclusions. Consult your tax advisor before excluding any classification(s) of employees.

4. The service period employees must complete before being eligible to participate is as follows:
   - ☐ As of date of hire or Plan effective date.
   - ☐ Number of days after date of hire: _____
   - ☐ Number of months after date of hire: _____

   Employees must be in service or on the job as one of the requirements.

5. Once the employees are eligible, they can begin participating in the plan:
   - ☐ First day of pay period following the date employee becomes eligible.
   - ☐ First day of month following the date employee becomes eligible.
   - ☐ First day of quarter following the date employee becomes eligible.
   - ☐ First day of Plan Year following the date employee becomes eligible.

6. Payroll Frequency
   - ☐ Weekly 52 beginning (date)_____
   - ☐ Bi-Weekly beginning (date)_____
   - ☐ Semi-Monthly _____
   - ☐ Monthly beginning _____
   - ☐ Any Omitted weeks _____

   Include information on any exceptions_____
   _____
   _____
   _____

BENEFITS

Check the benefits to be offered under this Plan:

- ☐ Core Health Benefits (Group Health)
- ☐ Non-Core Supplemental Health Benefits (Dental, Accident, Cancer, Heart, & Vision)
- ☐ Group Term Life Benefits (50,000 Maximum Employee Only)
- ☐ Short Term Disability Benefits
- ☐ Long Term Disability Benefits
- ☐ Health Savings Accounts
- ☐ Dependent Care FSA
- ☐ Health FSA
- ☐ Health Premium Reimbursement
- ☐ Cash Benefits

7. _____ Election must be made every year OR _____ Election rolls over by default (Evergreen)

CONTRIBUTIONS

Medical FSA Minimum: _____ Maximum: ($2750.00 for 2021) $_____
(Subject to changes by IRS)

Dependent Assistance: Minimum: $_____ Maximum: ($5000.00) $_____

BENEFIT COORDINATOR
THE BENEFIT COORDINATOR IS THE INDIVIDUAL AT THE EMPLOYER WITH WHOM EMPLOYEES SHOULD COMMUNICATE.

Name: _____ Title: _____

Telephone: _____ Fax: _____

E-mail: _____ Website: _____

OWNER, MANAGER, OR OFFICER AUTHORIZED TO ESTABLISH OR CHANGE CAFETERIA PLAN

Name: _____ Telephone: _____

Title: _____ E-mail: _____

ENROLLMENT & SERVICING AGENT

Name: _____ Telephone: _____

Title: _____ E-mail _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

BANK ACCOUNT ATTACH VOID CHECK (DO NOT COMPLETE IF VBA ACCOUNT IS USED)

(Fill the information below out only if the employer will be using their own bank account to fund accounts)

Name of Bank: _____

Bank Address:_____

Bank City:_____ Bank State:_____ Bank Zip Code:_____

Name on Account:_____

Account Number:_____

Bank Routing No. (MICR) (ex: 123456789):_____

Bank Routing No. (Bank Info) (ex: 111-42/348):_____

Person Signing check:_____

Standard Fees:

- ☐ Monthly Participant Admin Fees:$ 3.00 per employee, includes 2 debit cards
- ☐ Annual Fee of: $ 150.00 initially and for each subsequent plan year.
- ☐ Annual Fees waived for LICOA clients offering LICOA products exclusively.
  Please note that employers will still have a monthly participant fee.

Complete this statement to waive fees:

We will offer LICOA payroll deductions insurance plans exclusively to our employees during the plan year. Employees with other carriers will not be required to change their deductions. LICOA will offer limited underwriting on certain plans for employees desiring to make a change. Our representatives will provide you with the guidelines.

_____ _____

Signature of authorized person Date